

**Influenza – Report of Severe Illness (ICU Admission) or Death in Pregnant and PostPartum Women
Centers for Disease Control and Prevention**

Instructions: States are encouraged to use this form to report all pregnant and postpartum women with severe influenza admitted to an intensive care unit (ICU) or who died to the Maternal Health Team, CDC. Forms can be scanned and emailed, faxed, or called into the reporting line.

Email: ReportSickMom@cdc.gov

Fax: 404-248-4094

Reporting line (to reach a CDC staff member 24/7): 404-368-2133

Case ID:	
Medical record number:	
Contact name:	
Contact phone:	
Contact e-mail:	
Hospital name:	
Hospital zip code:	
Patient name:	
Patient DOB:	
State of residence:	

Patient Race:

- White
- Black/African-American
- Asian/Pacific Islander
- Native American/Alaskan Native
- Other
- Unknown

Patient Ethnicity:

- Hispanic
- Non-Hispanic
- Unknown

Insurance Type:

- Private health insurance
- Medicaid
- Self-pay
- Uninsured
- Unknown

Pregnancy classified as high-risk? Yes No Unknown

Underlying medical conditions/risk factors:

- Asthma
- Other chronic lung disease
- Pre-existing diabetes (prior to pregnancy)
- Gestational diabetes
- Obesity (prior to pregnancy)
- Cardiovascular disease, excluding hypertension
- Hypertension (prior to pregnancy)
- Gestational Hypertension/Preeclampsia/Eclampsia
- Seizure disorder
- Neurodevelopmental and/or neuromuscular disorder
- Tobacco use during current pregnancy
- History of tobacco use
- Immunosuppression If yes, specify _____
- Cancer diagnosed in last year
- Hemoglobinopathy
- Renal disease
- Other, specify: _____
- Unknown

Prenatal medications upon admission to hospital:

Estimated due date? __/__/__ Unknown

Gestational age at admission (wks): ____ Unknown

Date of symptom onset: __/__/__ Unknown

Date initial care sought: __/__/__ Unknown

Did mother receive rapid influenza test? Yes No Unknown

Result of rapid test? Positive Negative Unknown

Did mother receive rRT-PCR test? Yes No Unknown

Result of rRT-PCR test? Positive Negative Unknown

Did mother have any viral cultures? Yes No Unknown

Result of viral cultures? Positive Negative Unknown

Did mother receive DFA/IFA test? Yes No Unknown

Result of DFA/IFA cultures? Positive Negative Unknown

Did mother receive any influenza vaccine in 2009 or 2010 more than 2 weeks before onset of illness? Yes No Unknown

If yes, 2009 seasonal flu vaccine? Yes No Unknown

2009 pandemic H1N1 vaccine? Yes No Unknown

Did mother take antiviral medications after becoming ill?

Yes (list below) No Unknown

<input type="checkbox"/> Oseltamivir (Tamiflu®)	Dose _____ times/day Dates taken from ___/___/___ to ___/___/___
<input type="checkbox"/> Zanamivir (Relenza®)	Dose _____ times/day Dates taken from ___/___/___ to ___/___/___
<input type="checkbox"/> Rimantadine	Dose _____ times/day Dates taken from ___/___/___ to ___/___/___
<input type="checkbox"/> Amantadine	Dose _____ times/day Dates taken from ___/___/___ to ___/___/___
<input type="checkbox"/> Other	Dose _____ times/day Dates taken from ___/___/___ to ___/___/___
<input type="checkbox"/> Unknown antiviral	

Date of hospital admission: ___/___/___ Unknown

Admitted to ICU? Yes No Unknown

Date of ICU admission: ___/___/___ Unknown

Date of Final ICU discharge: ___/___/___ Not yet discharged Unknown

Date of hospital discharge/death: ___/___/___ Not yet discharged Unknown

Maternal death? Yes No Unknown

Other medications during hospitalization:

- Antibiotics
- Antihypertensives
- Vasopressors
- Systemic corticosteroids If yes, please specify reason (e.g. for maternal health or fetal lung maturity) _____
- Nebulized drugs (e.g. albuterol)
- Antiepileptics
- Antiglycemics
- Tocolytic agents
- Diuretics
- Other, specify: _____
- Unknown

Was she diagnosed with:

Pneumonia Yes, date: __/__/__ No Unknown
If pneumonia, was a bacterial culture obtained? Yes No Unknown
What was the culture site? _____
Result of bacterial culture? Positive Negative Unknown
ARDS Yes, date: __/__/__ No Unknown

Did she require mechanical ventilation?

Yes, then how many days?__ No Unknown

Date of delivery: __/__/__

Unknown

Delivery location:

- labor and delivery
- emergency department
- intensive care unit
- Other, specify: _____
- Unknown

Method of delivery:

- No Delivery
- Vaginal
- Cesarean, scheduled
- Cesarean, emergency
- Unknown

Other delivery details/complications:

Outcome:

- Live birth
- Stillbirth
- Unknown

Gestational age at delivery (wks): _____

Infant birthweight: _____ Unknown

Infant 1-minute Apgar? _____ Unknown

Infant 5-minute Apgar? _____ Unknown

Infant to NICU? Yes No Unknown

Date of infant discharge/death: __/__/__ Unknown

